Equity and excellence: Liberating the NHS

- Response to the Department of Health's consultation

October 2010

The Chartered Institute of Environmental Health

As a **professional body**, we set standards and accredit courses and qualifications for the education of our professional members and other environmental health practitioners.

As a **knowledge centre**, we provide information, evidence and policy advice to local and national government, environmental and public health practitioners, industry and other stakeholders. We publish books and magazines, run educational events and commission research.

As an **awarding body**, we provide qualifications, events, and trainer and candidate support materials on topics relevant to health, wellbeing and safety to develop workplace skills and best practice in volunteers, employees, business managers and business owners.

As a **campaigning organisation**, we work to push environmental health further up the public agenda and to promote improvements in environmental and public health policy.

We are a **registered charity** with over 10,500 members across England, Wales and Northern Ireland.

Any enquiries about this response should be directed in the first instance to:

Howard Price
Principal Policy Officer
Chartered Institute of Environmental Health
Chadwick Court
15 Hatfields
London
SE1 8D

Telephone 020 7827 5839
Email h.price@cieh.org

"Equity and excellence: Liberating the NHS"

– response to the Department of Health's consultation by the CIEH

Summary

Local authorities already play a large role in health protection and promotion, in particular through the work of their environmental health professionals. As their professional body, the CIEH welcomes the recognition of that through the government's plans to devolve greater responsibility for public health to them.

We are nevertheless concerned that proposals for a new, national Public Health Service excludes them while the joint appointment of Directors of Public Health will not be sufficient for various reasons to ensure a coherent approach to the protection of the public nationally and locally and we make suggestions for stronger frameworks to include environmental health professionals at every level.

Health protection and local authorities

The NHS touches everyone in various ways. First and foremost it treats our illnesses but though less well known by the public, it also has important health protection and promotion roles which are now well recognised as cost-effective in reducing health inequalities and extending healthy lives. The NHS is not alone in having those roles, however, local authorities actually having performed them for much longer. Indeed, they are the reason why local government as we know it was established.

Environmental health

Foremost among the resources local authorities have to perform them today are, of course, Environmental Health Professionals (EHPs) whose responsibilities range from improving air, land and water quality, to repairing cold, damp housing (where a variety of hazards cost the NHS c.£600M pa), safeguarding food standards, preventing workplace accidents and investigating outbreaks of infectious diseases. Albeit obliquely, the White Paper acknowledges the importance of what they do with references to "underlying risk factors" and "avoidable asthma admissions" (para 1.8), for example.

EHPs play parts too in the development control process, in licensing and in other functions of local councils (not least the growing carbon management agenda) which lead through "place-shaping" to better local environment quality and well-being.

Like that of the NHS, our model of environmental health is a world-leader and increasingly evidence-based; EHPs' services are available according to need and free at the point of delivery; unlike the NHS, however, the democratic control of local authorities means they are automatically closer and more responsive to their communities. "Localism" may be the

new term but it is not a new concept to environmental health services, yet - in places under-valued and fragmented - they, like the NHS, also need more stable and sustainable footings on which to build and deliver on nonetheless local and locally-determined outcome frameworks.

It is for all of these reasons that we welcome the proposed increased concentration in the Department of Health on public health and the transfer of responsibility for public health from patient-oriented PCTs to community-focussed and accountable local authorities. As it were "cutting out the middle man", along with the devolution of commissioning to GP consortia, should enhance the roles both of clinicians in treating the sick and of other, more appropriately qualified health professionals in preventing ill-health occurring. EHPs welcome (and, indeed, already enjoy) the opportunity of working in particular alongside health and social care colleagues, exploiting synergies with other local government services and look forward to benefiting from the "health premium" which will direct most funds to where they are most needed.

Contradictions and conflicts

We are nonetheless concerned that the new Public Health Service to be constructed mainly around elements of the Health Protection Agency will be seen (and, perhaps, see itself) as a central "elite" and excludes this larger, local workforce which not only carries the majority burden of health protection and improvement now but, of course, has overlapping roles in local resilience and public health emergencies too.

Notwithstanding the co-proposal to enact statutory duties of partnership (which only suggest some scepticism about the arrangement in government too) we would not be confident that the joint appointment of Directors of Public Health (DPHs) will be sufficient to bring the two elements – the new national centre and local authorities - together. That is, in particular, since though DPH posts are now open to non-clinicians and especially to specialists from local government backgrounds (and that must continue), the Public Health Service and local authorities will be culturally and in their governance very different organisations. Moreover while environmental health services will still be answerable to locally elected members, curiously and almost designed to produce conflict, the White Paper says that health improvement funding will be controlled by DPHs.

That – a local authority official holding a substantial budget independently of the authority - will be as far as we know a unique situation, notwithstanding that the mis-match in the numbers of local authorities and of DPHs (and the proposed solution to that involving only "upper tier" authorities) seems guaranteed to exclude many environmental health authorities from any future public health "family" anyway while it is not also proposed to relocate that function from districts to counties. Not least in respect of these districts it will be important, perhaps to the point of legislating for it, that though they already risk being over-large and unwieldy, the proposed "Health and Well-being Boards" include professional environmental health representation. Only that way, it seems to us, can they provide a comprehensive view of health improvement in balance with social care and commissioning,

fully reflect their constituent local authorities' roles and ensure that the key strategic needs assessments are complete.

To reinforce those in-puts further, and in any event, the CIEH proposes that there should be a national forum within the Department of Health, perhaps titled the National Health and Wellbeing Board, to help provide strategic direction to local partnerships and expertise and feedback on delivery to the department and that an environmental health perspective should be available both to that and at the highest level of the Public Health Service through reviving the appointment of a Chief Environmental Health Officer in government.

Similarly a cause of potential conflicts will be the situation of local HealthWatch, "funded by and accountable to local authorities" (para 2.26) yet with powers to support individuals who want to make a complaint about health and social care provision and to recommend that poor services are investigated while obvious questions about the basis on which its personnel will be selected and trained also go unaddressed.

These are not minor issues and they need to be resolved by the forthcoming Public Health White Paper if not before.

Performance

When it comes to performance, nevertheless, we hope that the same approach suggested for clinical services will be applied to public health ones, that is that it will be outcome-driven, quality rather than quantity-based with minimal targets and that professionals will be "responsible for determining how best to deliver" (para 3.4). Professional organisations like the CIEH can play an important role here, for example through providing best-practice advice and bench-marking but it will be important, however, to accept that public health outcomes take much longer to achieve than clinical ones and for many reasons are harder both to identify and to attribute.

Standards, education and training

We welcome the involvement of NICE in the development of standards which will extend to the work of local authorities and the Public Health Service (para 3.13) but, not least since that will be a new remit for NICE, suggest that service deliverers must play the main part in that work. Though it may be convenient that they do that through their relevant professional bodies, it is they who have the necessary expertise and insight and it is only consistent with the Paper's broader themes.

We are glad, too, to note the government's recognition of the role of research in underpinning quality, improving health outcomes and reducing inequalities and hope that that extends to research in areas of environmental health as much as in clinical health.
In addition, as in the NHS, local authority staff need to be "empowered, engaged and well-supported" (para 4.31) to perform their functions including through good quality training and education. That is another area in which professional bodies like ours have an

established and well-regarded role, in the CIEH's case as an Awarding Body, in the development of competency frameworks and in maintaining the register of public health specialists, for example, but training and education need funding and though the Paper notes that healthcare providers will meet the costs for NHS staff, it is not clear that local authorities – without the NHS's protected budgets – will do the same without an explicit requirement. Indeed we are already seeing sharp cuts in these budgets with reductions in the numbers of training placements for those at the start of their careers and in in-service training for those further on.

Clearly, the White Paper's proposals for public health are somewhat sketchy and we look forward to commenting more fully on the government's plans when those are published in greater detail in the Public Health White Paper later this year.

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